



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON COMMUNITY HOSPITAL
PO BOX 11586
HOUSTON TX 77293

Respondent Name

TWIN CITY FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-04-4637-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not respond to our "Request for Reconsideration". Carrier paid claim at per diem rate and not at Stop-Loss Threshold Reimbursement Factor."

Amount in Dispute: \$47,567.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the ACT. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor \$1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization. Such billing is utterly excessive and violates the cost containment policies of the Act and the Commission"

Response Submitted by: The Hartford, Josie Bloss, 300 South State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 30, 2003	Outpatient Surgery	\$47,567.68	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the

absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 23, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 4, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - M-In Texas, outpatient services are to be paid as fair and reasonable.
 - M-Reduced to fair and reasonable.
 - S-Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.
 - N-In order to review this charge we need a copy of the invoice detailing the cost to the provider.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Carrier did not respond to our "Request for Reconsideration". Carrier paid claim at per diem rate and not at Stop-Loss Threshold Reimbursement Factor."
 - The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 Texas Administrative Code §134.401(c)(6). The requestor asserts in the position statement that "Carrier paid claim at per diem rate and not at Stop-Loss Threshold Reimbursement Factor." 28 Texas Administrative Code §134.401(b)(2)(A) states "General Information. (A) All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care inpatient services rendered shall be the lesser of (iii) reimbursement as set out in subsection (c) of this section for that admission." Because this was an outpatient hospitalization this admission is exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1
 - The requestor did not discuss or explain how it determined that the Stop-Loss Threshold Reimbursement Factor, 75% of the amount billed, would yield a fair and reasonable reimbursement.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of

the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	1/5/2012 _____ Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	1/5/2012 _____ Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.